Clinical Quality

Value-based purchasing in
Wisconsin Family Medicaid and BadgerCare

MEDDIC-MS Data Book
Vol. 1--2006 Overall Performance Data

Wisconsin Department of Health and Family Services
Division of Health Care Financing, Bureau of Managed Health Care Programs

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Wisconsin Family Medicaid and BadgerCare

Quality Assessment and Performance Improvement

MEDDIC-MS Data Book *Volume 1: 2006 Overall Performance Data*

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Introduction and Background

Quality assessment and performance improvement is a central element in Wisconsin's value-based purchasing strategy. Automated performance measures allow performance data to be generated across a wide range of clinical care areas at very low cost and no disruption to provider clinics and hospitals. Quality data is used for quality improvement by health plans and by the Department of Health and Family Services (DHFS). Public reporting of the data supports transparency and accountability.

MEDDIC-MS (Medicaid Encounter Data Driven Improvement Core Measure Set) is Wisconsin's set of automated performance measures for Family Medicaid and BadgerCare (the State Children's Health Insurance Program or SCHIP) managed care.

Use of MEDDIC-MS was approved by the Centers for Medicare and Medicaid Services (CMS) as part of its review of the state's quality improvement strategy in August 2003. CMS has recognized MEDDIC-MS, MEDDIC-MS SSI and the goal-setting system as Medicaid/SCHIP/SSI "Promising Practices. For more information, go to: http://www.cms.hhs.gov/MedicaidSCHIPQualPrac/MSPPDL/list.asp?listpage=2

The Agency for Healthcare Research and Quality (AHRQ) has approved MEDDIC-MS and MEDDIC-MS SSI for inclusion in the National Quality Measures Clearinghouse (NQMC®). View the measure summaries on the NQMC at: http://www.qualitymeasures.ahrq.gov/browse/measureindex.aspx and scroll down to "State of Wisconsin."

MEDDIC-MS and MEDDIC-MS SSI performance measures are approved for health plan accreditation by URAC® (Utilization Review Accreditation Commission) and by the Accreditation Association for Ambulatory Health Care (AAAHC®) for Medicaid, SCHIP and SSI populations.

Technical specifications for the performance measures and previous quality performance reports are available online at: http://www.dhfs.state.wi.us/medicaid7/reports_data/quality_reports/index.htm

Results on each measure are calculated by a third party, not by HMOs or providers, improving consistency and accuracy. To drive performance improvement, an integral goal-setting system applies to some measures.

The data in this booklet presents program-wide performance rates for all HMOs combined on the MEDDIC-MS performance measures based on calendar year 2006 data, as well as trend data based on past performance.

New Enrollee Health Needs Assessment (NEHNA) survey

Wisconsin has a mechanism to identify enrollees' health care needs, including special health care needs called the New Enrollee Health Needs Assessment (NEHNA) survey. The NEHNA survey is administered by the state's enrollment broker at the time of enrollment and will soon be available to prospective enrollees online. The information is shared with the enrollee's HMO. In this way, the DHFS facilitates quality care by informing HMOs of the health care needs of new enrollees, even before the enrollee may have a visit with their doctor.

Care Analysis Projects

DHFS has implemented an advanced care management support system called the Care Analysis Project (CAP). Through CAP, enrollee-specific health care needs are identified from encounter data and those needs are shared with the enrollee's HMO. Through CAP, DHFS assists HMO outreach to individuals with special health care needs.

CAP focuses on several chronic conditions and on the provision of key preventive services. Chronic conditions included are congestive heart failure, asthma, and diabetes. Preventive health services include lead screening and prenatal risk assessment.

MEDDIC-MS and CAP work together. CAP provides data-driven targeted intervention and MEDDIC-MS provides performance assessment.

HMO Performance Improvement Projects

Each year, HMOs complete at least two performance improvement projects. These projects effectively drive quality improvement. To view a summary of HMO Performance Improvement Project topics, go to:
HTTP://WWW.DHFS.STATE.WI.US/MEDICAID7/REPORTS_DATA/QUALITY_REPORTS/MCORGPERIMP.HTM

Other volumes in the Data Book include:

MEDDIC-MS 2006 Data Book, Volume 2, HMO-specific Performance Data, Wisconsin Family Medicaid and BadgerCare.

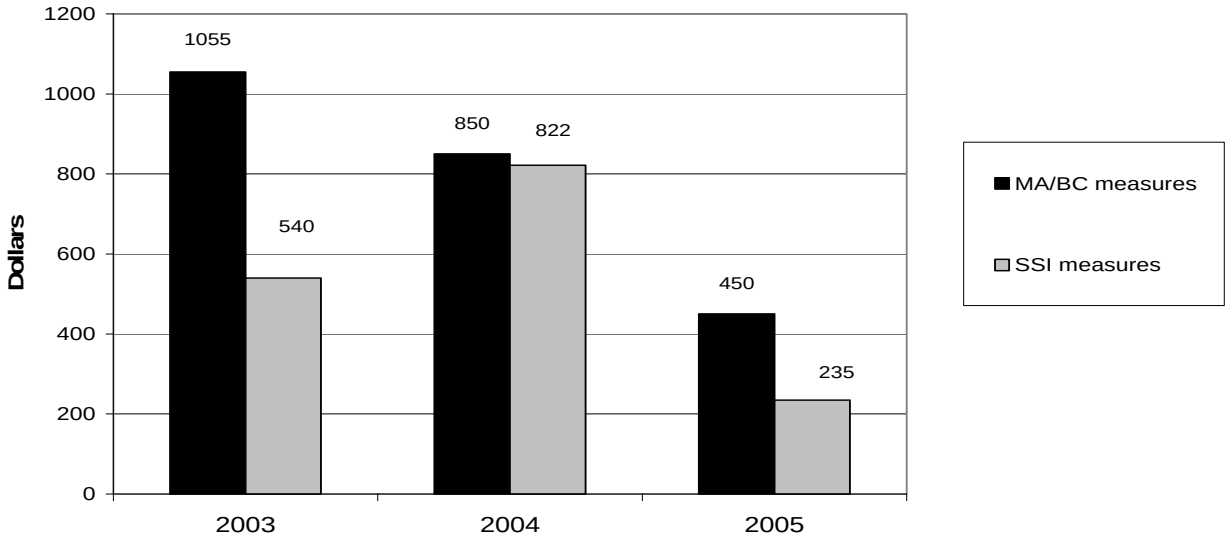
MEDDIC-MS SSI 2006 Data Book, Volume 1, Overall SSI Program Performance

MEDDIC-MS SSI 2006 Data Book, Volume 2, HMO-specific Performance

Cost-effective quality assessment

Non-care administrative costs such as those associated with performance measurement can drain away resources that could otherwise be used to provide care. Wisconsin's automated performance measures have proven effective in driving down non-care administrative costs compared to older, non-automated systems. This chart shows actual per-measure costs for operation of Wisconsin's automated performance measures from 2003-2005.

MEDDIC-MS (for Medicaid/BadgerCare--MA/BC) and MEDDIC-MS SSI average per-measure cost (actual) 2003-2005



The costs of operating older, non-automated measures, particularly those involving medical record review are much higher. A recent IOM report[1] cited per-record costs for medical record review of $20 and higher. The report revealed one typical health plan spent $107,000 *on medical record review alone* to report on *only six measures* for a small sample of its enrollees.

That is an average per-measure administrative cost of $17,833 for data acquisition alone, not including added costs for software, which in one case in the IOM report was over $30,000. Also, costs for full or part time help added for the purpose of managing the data gathering and reporting functions were not included.

[1] "Performance Measurement: Accelerating Improvement," Committee on Redesigning Health Insurance Performance Measures, Payment and Performance Improvement Programs, Board on Health Care Services, Institute of Medicine, National Academies Press.

Executive Summary—

Sustained improvement has occurred in many areas, but performance improvement opportunities remain

Summary of trends on selected measures from 2000 to 2006

Positive trends

- ***Asthma care:*** Prevalence of asthma increased slightly, but the need for emergency department services for asthma declined from 25.9 to 21.8 percent and the need for inpatient care declined from 7.6 to 5.3 percent.
- ***Blood lead toxicity screening:*** The screening rate for one-year-old children has increased from 59.9 percent in 2000 to 69.6 percent in 2006. The screening rate for two-year-old children increased from 47.7 percent in 2000 to 52.6 percent in 2006.
- ***Childhood immunizations:*** rate for children with full immunization status[2] increased from 38.2 to 68.9 percent. Pneumococcal vaccine administration rates increased from 29.8 percent in 2002 to 67.4 percent in 2006.
- ***Dental preventive care:*** rates improved for adults (age 21+) from 10.3 to 23.5 percent.
- ***Dental (general) care:*** this rate includes all dental services. It increased from 4.3 percent in 2002 to 15.7 percent in 2006. However, this rate is lower than each of the past three years. The national average is 37.7 percent.[3]
- ***Diabetes care:*** hemoglobin A1c (HbA1c) testing rate improved from 70.7 to 84.1 percent (the national average is 81.5 percent[4]) and lipid profile testing rate improved from 45.7 to 70.4 percent for adult diabetics. HbA1c rates improved even more for children and adolescents with diabetes increasing from 65.8 percent to 85.4 percent; lipid profile rates increased from 11 percent to 21.7 percent.
- ***EPSDT (HealthCheck) well-child exams:*** rate for children age 2 years and younger receiving 7 or more exams improved from 45.5 to 69.1 percent. Rates for older children receiving at least one exam increased in each age cohort, by an average of approximately 3 percent.
- ***Mammography (breast cancer detection for women):*** rate increased from 22.9 to 29.0 percent for women age 40-49. For women 50+ years of age, the rate increased from 32.4 to 35.0 percent. While these rates show some improvement, they are far below the national average, which was 74.4 percent[5] for women over 40 years of age.
- ***Maternity care:*** Voluntary HIV testing in the perinatal period increased from 16.6 to just over 25.7 percent.

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[2] Based on Centers for Disease Control (CDC) Advisory Committee on Immunization Practices (ACIP) recommendations.
[3] **Medical Expenditure Panel Survey (MEPS) Database Chartbook #13**, AHRQ, for rural and urban all individuals under age 65.
[4] **National Healthcare Quality Report 2006**, Agency for Healthcare Research and Quality.
[5] **National Healthcare Quality Report 2006**, Agency for Healthcare Research and Quality.

- ***Mental health/substance abuse post-discharge follow-up care:*** Follow-up care within 7 days by specialist increased from 25 to 26.4 percent; within 30 days increased from 41.1 to 47.3 percent. Follow-up care within 7 days by primary care providers increased from 1.4 percent to 2.8 percent and increased from 4 percent to 9 percent for care within 30 days.
- ***Mental health/substance abuse outpatient evaluations:*** Increased from 3.5 percent to 5.0 percent.
- ***Non-EPSDT well-child exams:*** The rate for children birth to age 1 year increased from 69.9 to 96.6 percent. Rates of provision of this service increased in all other age cohorts up to age 21 years as well.

Flat trends

- ***Primary care access:*** has remained stable at about 80 percent of enrollees of all ages having at least one encounter in the look-back period. The national average is 67.2 percent.[6]
- ***Emergency department utilization without resulting in inpatient admission:*** This measure is thought of as one indicator of adequacy of access to primary care. It has remained stable at about 35 percent.
- ***Vision and audiology***: Access rates remained about the same at about 3 percent and 1.5 percent respectively.
- ***General & specialty inpatient care:*** Rates for inpatient services generally remained about the same, with neonatal care decreasing from 95 to 83 percent.
- ***Maternity care:*** Substance abuse treatment in the perinatal period remained stable at about 1 percent. Prenatal care coordination (PNCC) also remained stable and at less than one percent.
- ***Substance abuse outpatient care:*** Substance abuse outpatient care by all provider types remained stable under 0.5 percent from 2000 to 2006.
- ***Pap tests (cervical cancer detection for women):*** This rate wavered between 35 and 42 percent. Malignancy and HPV detection rates were stable but significantly lower than the national average, which was 82.3 percent in 2004.[7]

Negative trends

- ***Dental preventive care:*** rates for children age 3 to 20 years decreased from 16.8 percent to 15.8 percent after four consecutive years of improved performance from the baseline.
- ***Maternity care:*** C-section rate increased for the fifth straight year from 12.9 (2000) to 21.4 percent.
- ***MH/SA evaluations and outpatient care:*** Behavioral health outpatient treatment by specialists decreased from 5.8 to 5.3 percent after four consecutive years of improved performance. Behavioral health treatment by

[6] **Medical Expenditure Panel Survey (MEPS) Database Chartbook #13**, AHRQ, for rural and urban all individuals under age 65.
[7] **National Healthcare Quality Report 2006**, Agency for Healthcare Research and Quality.

primary care providers (PCPs)/others increased from 3.9 to 4.2 percent, but was down from the four previous years.

Analysis

Performance data trended from 2000 to 2006 shows that, on a majority of measures, the quality improvement strategy to "ramp up" performance over time appears to be effective. However, performance on some indicators lags below national averages, despite positive trends. Delivery of Pap test and mammography services are examples.

Performance has been flat and on some others, performance improvement has begun to level off after a period of sustained improvement. Most of those instances are in areas where further improvement should be possible.

Those clinical areas where multiple strategies have been implemented appear to have the most significant improvements. Strategies include HMO performance improvement projects, pay-for-performance (P4P) incentives, disease management by HMOs, data sharing and targeted outreach under the Care Analysis Project (CAP), and early care need identification using the NEHNA (New Enrollee Health Needs Assessment) survey.

For example, emergency department and inpatient care utilization for asthma declined from 2000 to 2006, even though disease prevalence increased slightly (see page 13). Asthma is included in the DHFS Care Analysis Project (CAP) and care need information is provided to HMOs through the NEHNA survey. Also, twelve HMOs have disease management for asthma (up from nine in 2003) and nine HMOs have conducted performance improvement projects on the subject since 2000.

Similarly, diabetes care indicators exhibited sustained improvement between 2000 and 2006 (see page 16). Diabetes is included in the Care Analysis Project and NEHNA survey. It has been the subject of seven HMOs' performance improvement projects since 2000 and eleven HMOs have disease management for diabetes.

Performance improvement opportunities exist in several areas, for example, dental services, provision of Pap tests and screening mammography. In addition, steps may be necessary to re-energize improvement efforts in areas where improvement appears to be leveling off.

Strategic options

These findings suggest several strategy options for further quality performance improvement program-wide. They include:

- Broaden the Care Analysis Project to include additional topics.
- Increase new enrollee participation in the NEHNA survey. This is being implemented as part of BadgerCare Plus.
- Increase the number of topics included in the performance improvement goal-setting system. For 2007-2008, the Pap test and Mammography indicators have been added to goal-setting.
- Broaden the use of pay-for-performance incentives. This is being implemented as part of BadgerCare Plus.
- Consider options to increase the number and effectiveness of HMO performance improvement projects.
- Implement member-centric healthy living incentives. This is being implemented with BadgerCare Plus.

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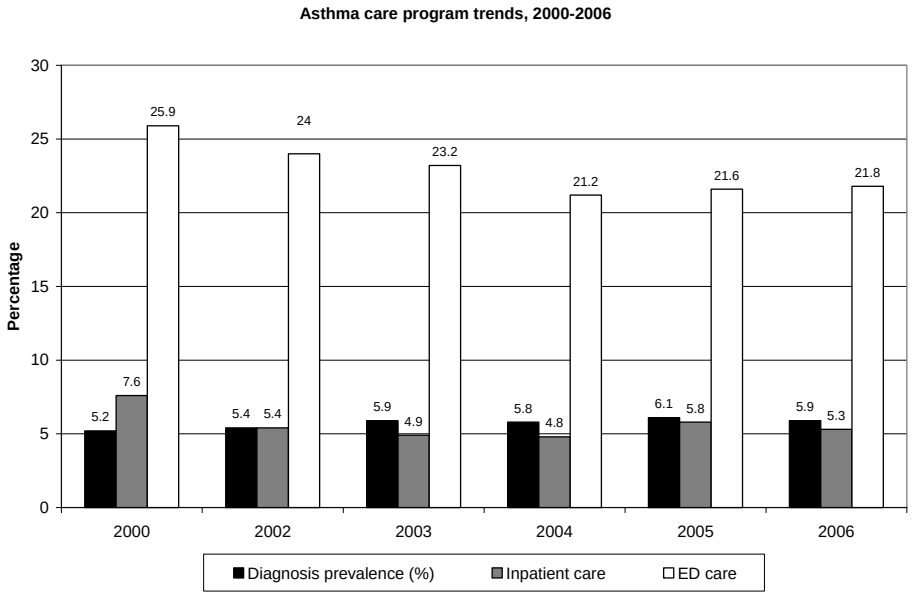
Results on Clinical Performance Measures

Asthma care

Monitoring measure

Data points—

- Asthma prevalence increased slightly since 2000.
- Utilization of both emergency department care and inpatient care has declined between 2000 and 2006.
- Emergency care for asthma decreased from 25.9 percent in 2000 to 21.8 percent in 2006.
- Inpatient care for asthma declined from 7.6 percent in 2000 to 5.3 percent in 2006.



Asthma is a chronic disease of the lungs. Asthma causes episodes where airflow in and out of the lungs is reduced by constriction of the airways and by excess mucous.

Asthma can be managed with appropriate medications and patient education. According to a large study[8] published in May 2006, 34 percent of asthmatics without insurance coverage used urgent or hospital emergency department care for severe asthma symptoms—more than 12 percent higher than enrollees in Wisconsin Medicaid/BadgerCare HMOs.

HMO disease management programs for asthma may have been an important factor in the improvement; twelve Medicaid/BadgerCare HMOs offer asthma disease management. In addition, nine HMOs have conducted performance improvement projects on asthma care since 2000. Also, the DHFS has operated a Care Analysis Project on asthma since 2001 and it is an item on the New Enrollee Health Needs Assessment (NEHNA) survey.

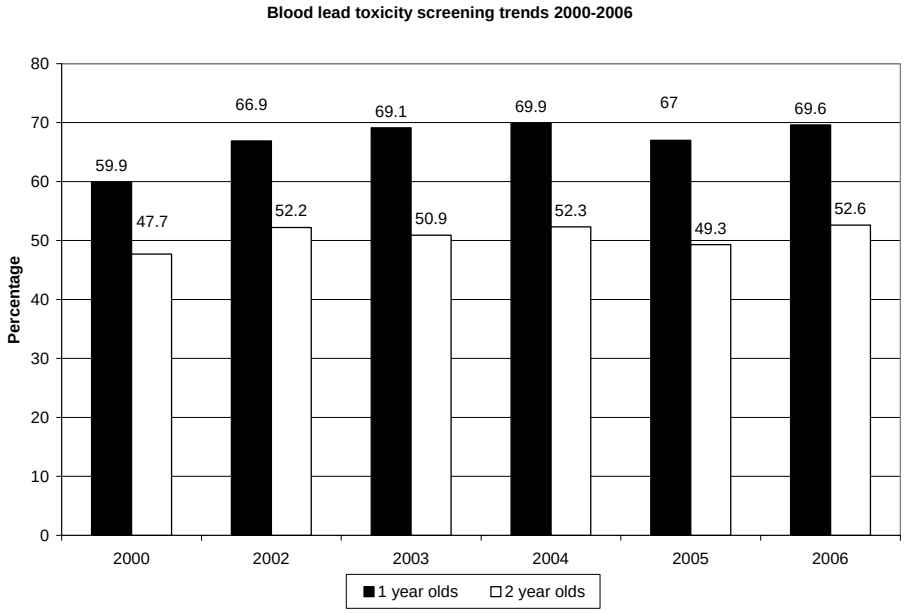
[8] *"Lack of insurance and urgent care for asthma—a retrospective cohort study,"* BMC Public Health. 2006;6 ©2006 Markovitz et al.

Blood lead toxicity screening

Targeted performance improvement measure

Data points—

- The screening rate for one-year-old children has increased from 59.9 percent in 2000 to 69.6 percent in 2006.
- The screening rate for two-year-old children increased from 47.7 percent in 2000 to 52.6 percent in 2006.
- Since 2000, seven HMOs have conducted performance improvement projects on lead screening.



Children in Medicaid are at risk for exposure to lead in their living environment. Screening for blood lead toxicity is required for children at age one and two years and up to age six if elevated blood lead levels or risk factors are present.

In 2001, the Department implemented a Care Analysis Project (CAP) on blood lead toxicity screening. Recipient-specific lead testing data is shared with the individual's HMO in an effort to assist HMOs with identification of children in need of lead screening. This facilitates outreach and follow-up for children who have not received screening. This on-going effort may be a factor in the improvement in the lead screening rate trends.

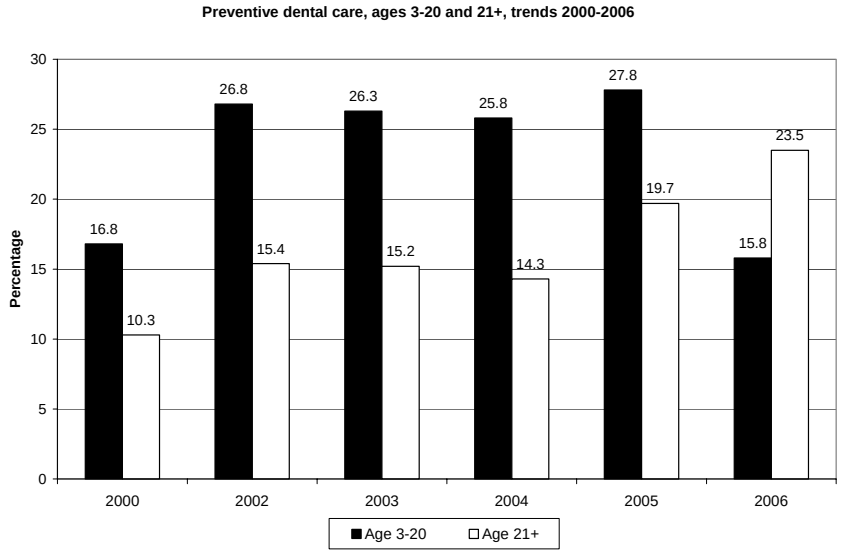
HMO performance improvement goal-setting applies to this measure and an HMO pay-for-performance incentive applies to this service.

Dental (preventive) services

Targeted performance improvement measure

Data points—

- The preventive dental services rate for children had increased 11 percentage points 2000-2004, but declined in 2006.
- The rate for adults has increased 13.2 percentage points.
- Additional performance improvement strategies are being implemented, including an HMO pay-for-performance incentive.



Preventive dental services include initial and comprehensive dental examinations, prophylaxis, topical application of fluoride and application of sealants.

Dental care soon after the eruption of teeth can prevent development of dental caries, tooth loss, oral infections, abscesses and other problems. Teeth generally first erupt between age 6 and 28 months and emerge enough to benefit from preventive care between 1 and 3 years.

In 2006, four HMOs in the Milwaukee area offered dental services. HMO enrollees in the rest of the state receive dental benefits on a fee-for-service basis.

Despite apparent initial improvement in access indicated by higher utilization for both age groups, the overall percentage of enrollees receiving preventive dental services remains relatively low and a decline in services for children occurred in 2006. Improving delivery of dental care remains a performance improvement opportunity.

Diabetes care

Targeted performance improvement measure

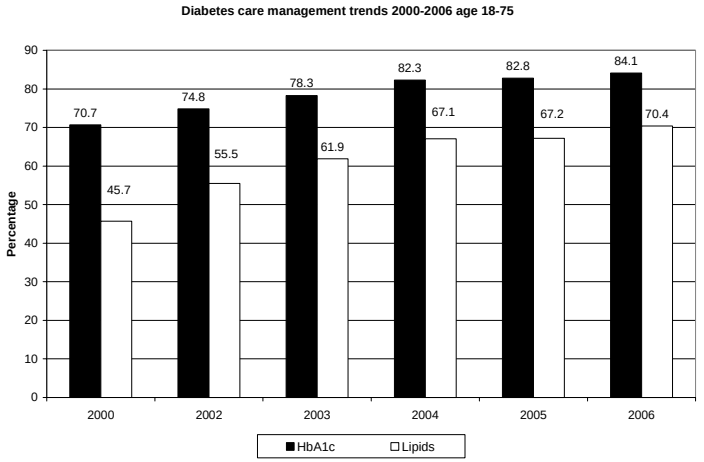
Data points—

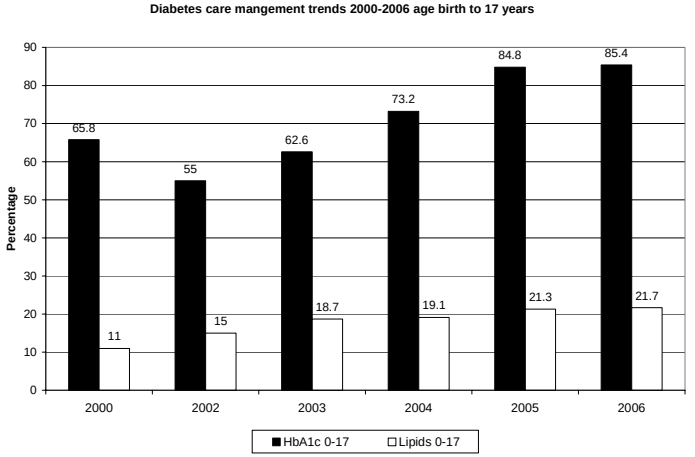
- Performance improved on all indicators for all ages.
- Lipid test rates for 18-75 year olds increased from 45.7 percent in 2000 to 70.4 percent in 2006.
- The HbA1c test rates for 18-75 year olds increased from 70.7 percent in 2000 to 84.1 percent in 2006.
- The HbA1c rate for 0-17 years of age increased from 65.8 percent in 2000 to 85.4 percent in 2006.
- The rate for lipid testing for 0-17 years of age has also improved, increasing from 11 percent in 2000 to 21.7 percent in 2006.
- Diabetes care management outcome data since 2004 shows that both emergency department care (ED) and inpatient care due to diabetes has been consistently low.

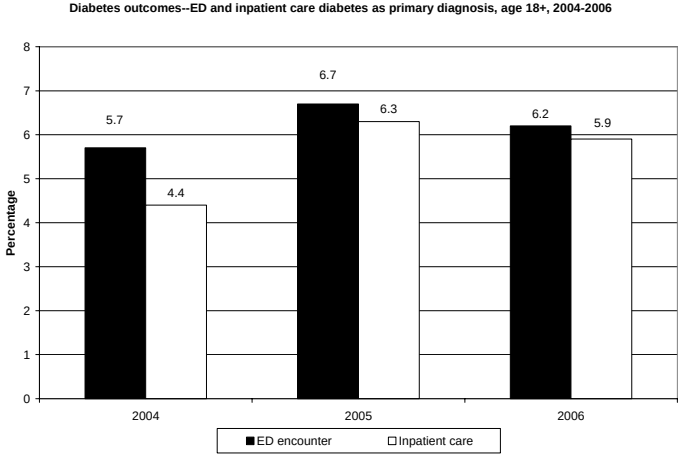
Diabetes mellitus is a chronic condition that can affect the heart, kidneys and eyes. Two blood tests are important for effective diabetes care.

One is the hemoglobin A1c (HbA1c), a blood test that indicates the level of blood sugar control over time. The lipid profile monitors the levels of "fats" (lipids) in the blood.

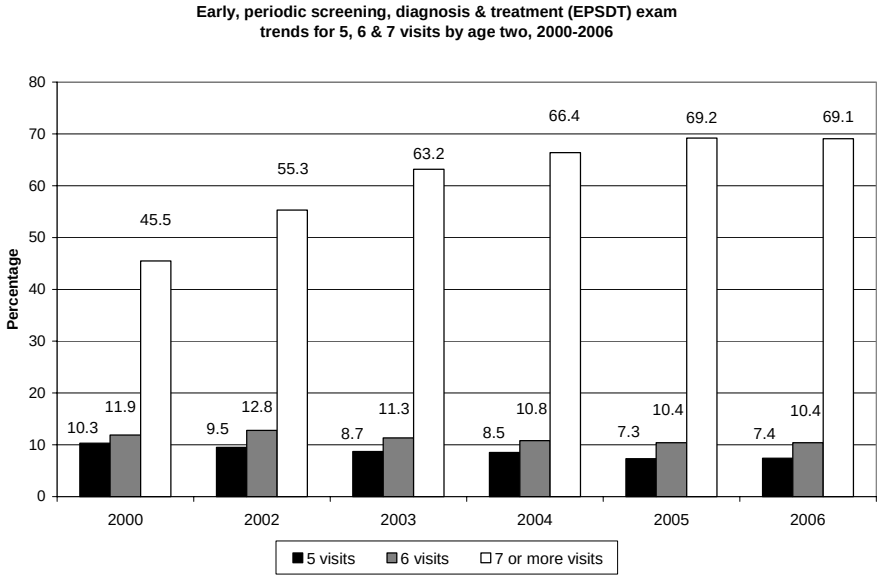
Seven HMOs have conducted performance improvement projects on diabetes care since 2000 and eleven HMOs have disease management programs for diabetes. It is an item on the New Enrollee Health Needs Assessment (NEHNA) survey and it has been a Care Analysis Project topic since 2001.

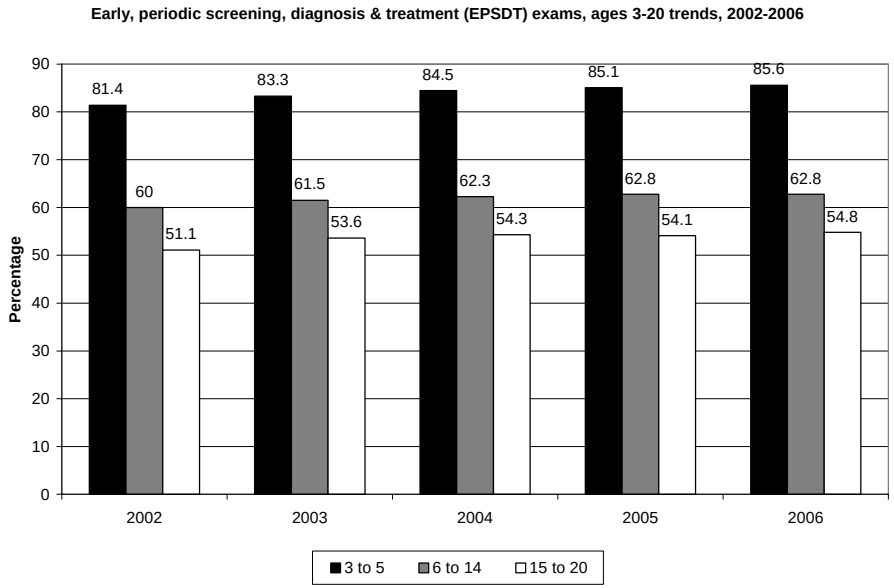






EPSDT comprehensive well-child exams *Monitoring Measure*





Data points—

- The rate for children receiving 7 or more EPSDT exams by age two years has increased from 45.5 percent in 2000 to 69.1 percent in 2006.
- The rates for children age 3 to 5 years of age receiving at least 1 visit in the look-back period has remained higher than 80 percent since 2002.
- Small improvement has occurred in older age cohorts since 2002.

Early, Periodic Screening, Diagnosis and Treatment (EPSDT) services are federally required for children in Medicaid. Wisconsin calls EPSDT services HealthCheck screens.

EPSDT exams include an unclothed physical exam, age appropriate immunizations, lab work, including blood lead toxicity tests, health and developmental history, vision and hearing assessment and oral assessment beginning at age 3. Ten HMOs have conducted performance improvement projects on HealthCheck since 2000. An HMO pay-for-performance incentive applies to this service.

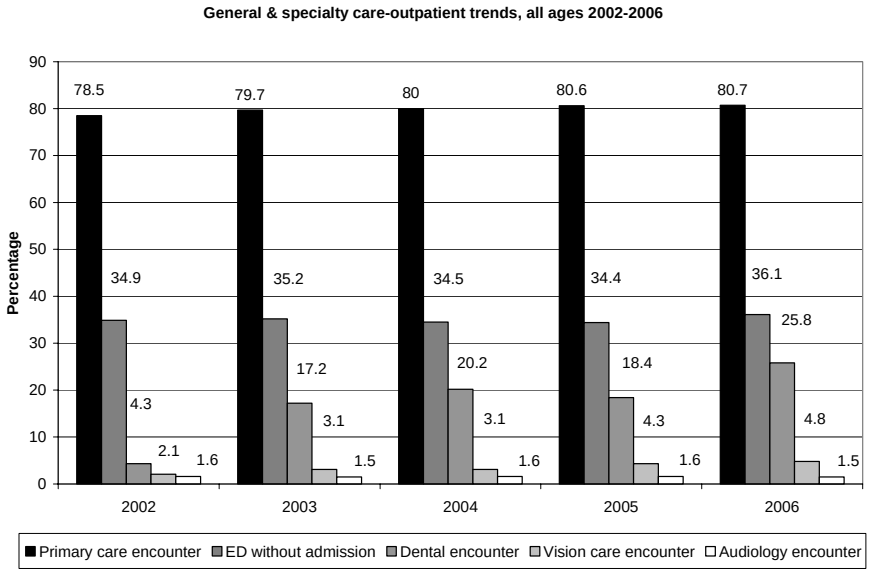
Data for age groups 3-20 years was not calculated in 2000-01.

General and specialty care-outpatient

Monitoring measure

Data points—

- Eight out of ten HMO enrollees have at least one primary care encounter per year.
- About one in three enrollees had at least one emergency department (ED) care encounter that did not result in subsequent hospitalization.
- Access to vision and hearing services remained stable.
- Access to general dental services has increased from 2002 to 2006, but additional strategies for improvement will be implemented.



This measure assesses access to primary care, emergency care that does not result in subsequent hospitalization, vision care, audiology services and general dental care. Access to these outpatient or ambulatory care services is essential for overall health maintenance and improvement.

The measure tracks what percentage of Medicaid and BadgerCare HMO enrollees had access to those services on at least one occasion during the look-back period; many enrollees had multiple encounters of each type.

Four HMOs provide dental care under their contract with the Department. General dental services include interventions such as fillings, extractions and so on, as well as all preventive services. See also "Dental (preventive) care" on page 10 for further information on other dental care services.

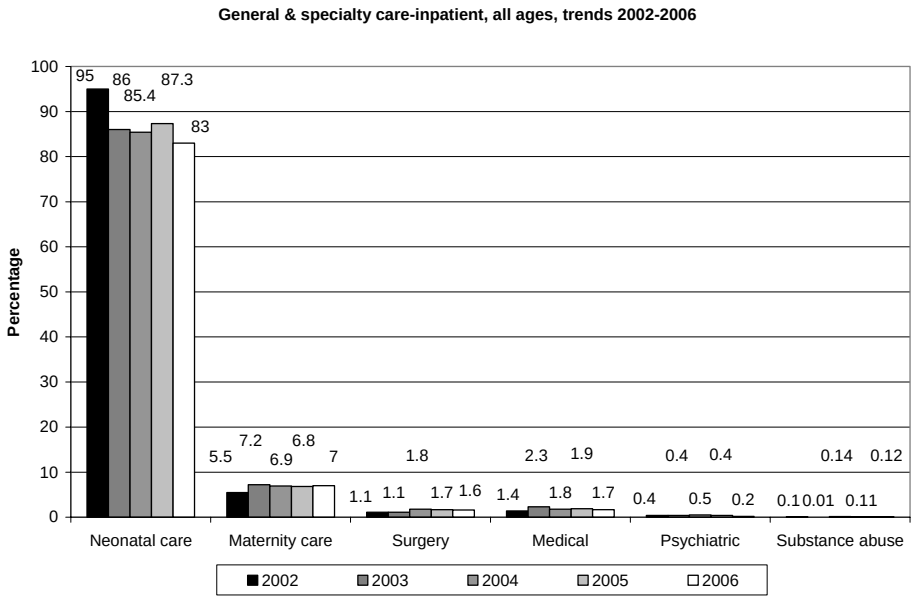
The need for vision, audiology and other special outpatient care services are an item on the New Enrollee Health Needs Assessment (NEHNA) survey.

General and specialty care-inpatient

Monitoring measure

Data points—

- Neonatal care has remained above 80 percent from 2002 to 2006.
- Maternity, surgical, medical, psychiatric and substance abuse care rates have remained about the same from 2002 to 2006.



Some conditions may require hospital or *inpatient* care.

General categories of care monitored include maternity, surgery, medical, psychiatric, substance abuse and neonatal (newborn) care.

By itself, this measure is not an all-inclusive indicator of sufficiency of access to services, or of appropriateness of care. However, when used in conjunction with other data such as satisfaction, external quality review, grievance and appeal data, outpatient care data and other measures, it provides a reasonable basis for assessment of overall inpatient general and specialty care.

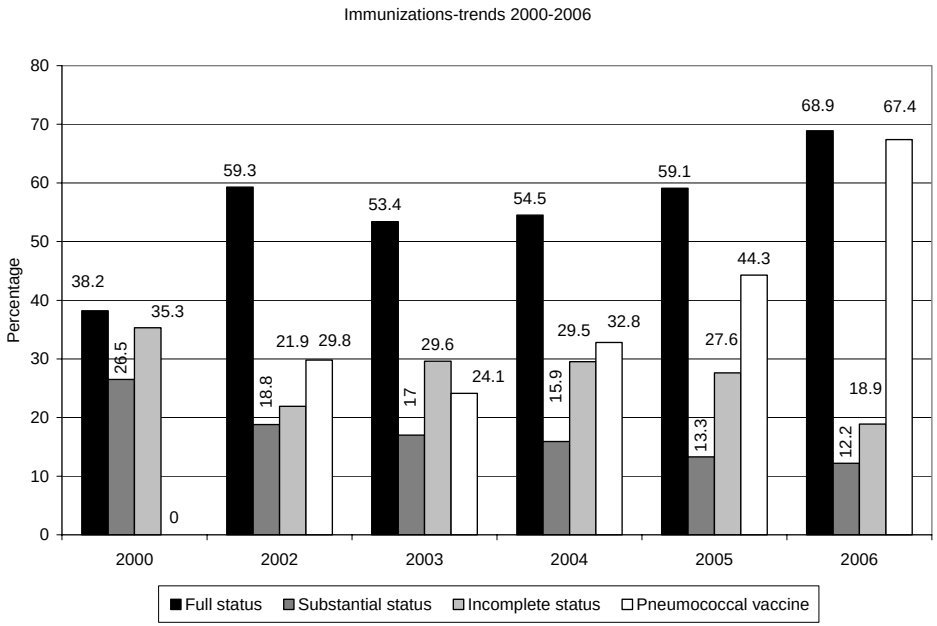
Information about enrollee inpatient care needs is an item on the New Enrollee Health Needs Assessment (NEHNA) survey.

Immunizations for children

Targeted performance improvement measure

Data points—

- The rate of full immunization status has increased 80.3 percent since 2000. Vaccine shortages from 2002 to 2004 have adversely affected performance in the period.
- The rate for children receiving 4 doses of pneumococcal vaccine more than doubled, increasing from 29.8 percent in 2002 to 67.4 percent in 2006.
- Vaccine shortages also affected the rate of pneumococcal vaccination in that time period and remain a factor in the delivery of some antigens.



Immunizations can protect young children from potentially serious infectious diseases. Immunization is believed to be one of the safest and most effective health care services available.

This measure assesses the percentage of children enrolled in Medicaid/BadgerCare HMOs who have achieved full immunization status, substantial immunization status and who have incomplete immunization status. The rate of administration of 4 doses of the multivalent pneumococcal vaccine is included as a monitoring measure. Substantial status refers to children who have received most but not all of the doses of certain vaccines given in multi-dose series believed necessary to confer substantial immunity.

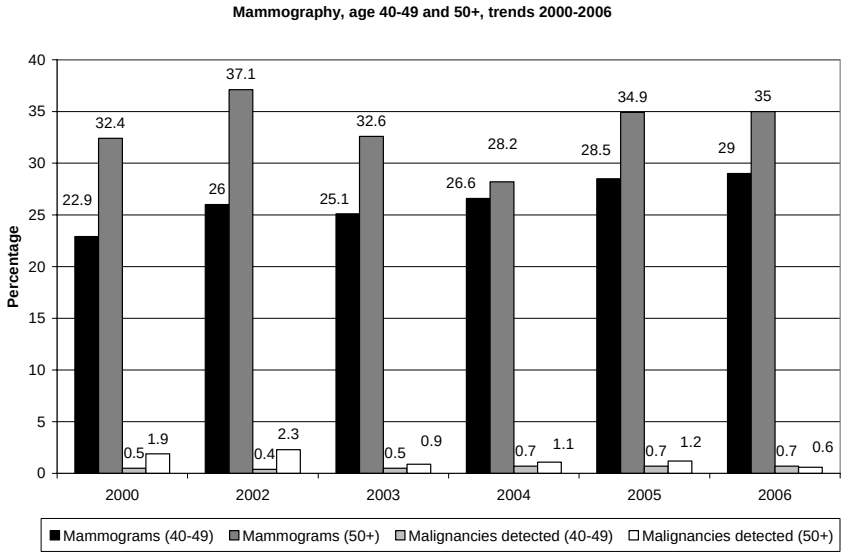
Five HMOs have made childhood immunizations the subject of performance improvement projects since 2000. DHFS performance improvement goal-setting is in effect for this measure.

Mammography (screening) and malignancy detection

Monitoring measure

Data points—

- The percentage of women screened in the 40-49 age group has increased since 2000, from 22.9 percent to 29 percent.
- The rate for women over age 50 has increased since 2000, from 32.4 percent to 35 percent.
- Detection of breast malignancies has ranged from 0.4 percent to 0.7 percent in the 40-49 year age group since 2000. The malignancy detection rate in the 50+ age group has ranged from a high of 2.3 percent in 2002 to a low of 0.6 percent in 2006.



Screening mammography is recognized as a highly effective method for early detection of breast cancer. Early detection of breast cancer improves outcomes of treatment and long-term survival.

The American Cancer Society and the National Cancer Institute each recommend that women over age 40 have regular screening mammograms.

Only a small percentage of enrollees in Medicaid/BadgerCare are women over age 40. Nevertheless, provision of screening mammography is important because of the benefits of early detection and treatment.

This measure assesses screening mammography rates for women aged 40-49 and over age 50 years, as well as malignancy detection rates.

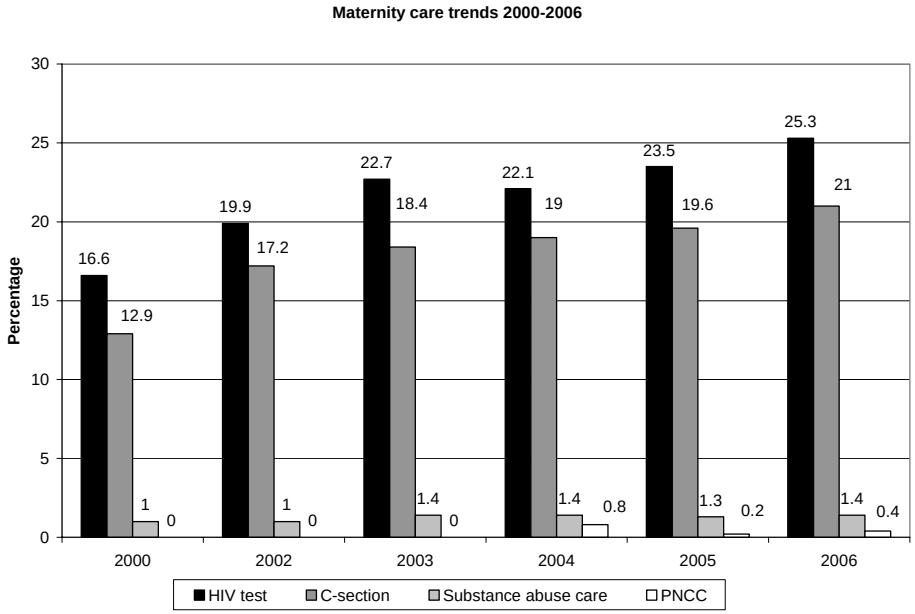
Two HMOs have conducted performance improvement projects on mammography services since 2000. The service has been added to the goal-setting system.

Maternity care

Monitoring measure

Data points—

- Provision of HIV screening increased from 16.6 percent in 2000 to 25.3 percent in 2006.
- The rate of births by C-section has steadily increased from 12.9 percent in 2000 to 21.0 percent in 2006.
- Provision of substance abuse care in the perinatal period remained stable at just over 1.0 percent.
- PNCC was not calculated in 2000 and 2002. The rate has remained under one percent since 2003.



Due to the number of women of child-bearing age in Medicaid/BadgerCare, tracking maternal care services is important. Cesarean section (C-section) childbirth may be medically necessary in certain circumstances. However, growing numbers of "elective" procedures are occurring.[9] According recent data from the Centers for Disease Control and Prevention, the national C-section rate increased 21.6 percent between 1995 and 2001.[10] In Wisconsin, C-sections are increasing faster than the national average (a 62.7 percent increase 2000-2006).

Three other important perinatal services are substance abuse treatment services, voluntary HIV screening tests and prenatal care coordination (PNCC) for high-risk pregnancies.

Ten HMOs have conducted performance improvement projects on prenatal or maternal care since 2000, including several in support of a collaborative project since 2005. Other combined efforts to improve birth outcomes include the Department of Public Health and Division of Health Care Financing. Information about pregnancy is gathered with the New Enrollee Health Needs Assessment (NEHNA) survey.

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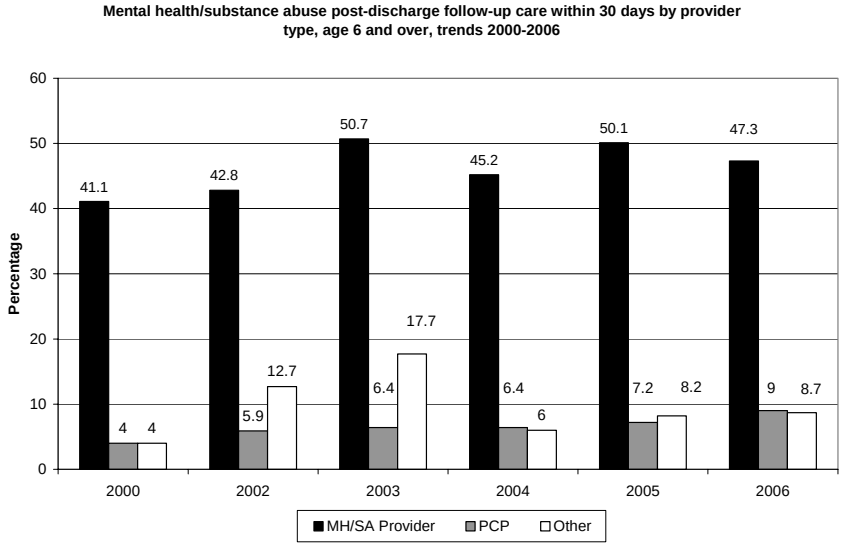
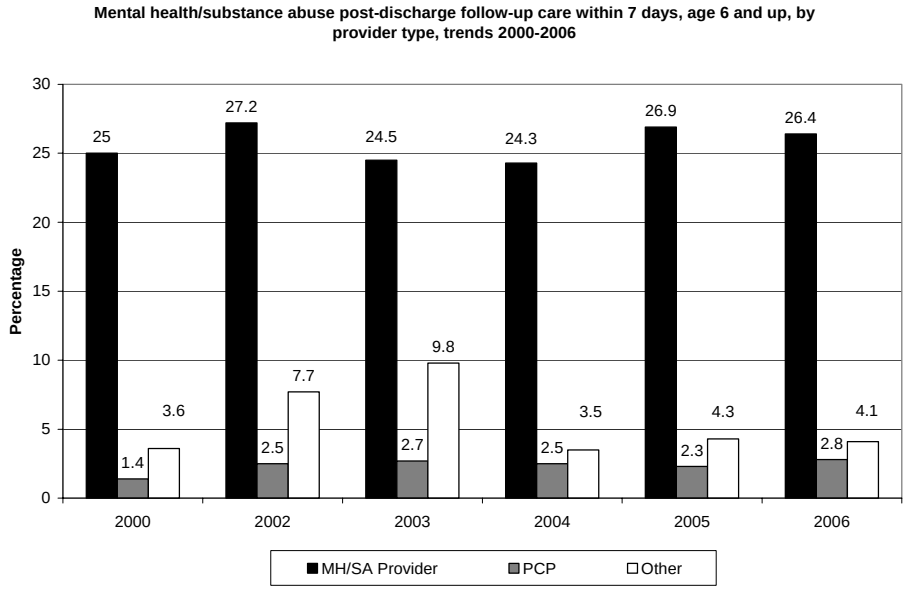
[9] *Cesarean Delivery on Maternal Request,* Evidence Report (Publication No. 06-E009), Evidence-based Practice Center: RTI-University of North Carolina, March 2006.

[10] Kozak LJ, Owings MF, Hall MJ. National Hospital Discharge Survey: 2001 annual summary with detailed diagnosis and procedure data. National Center for Health Statistics. Vital Health Stat 13(156). 2004.

Mental health/substance abuse (MH/SA) follow-up care within 7 and 30 days of inpatient discharge

Targeted Performance Improvement Measure





Data points—

- Follow-up care by specialty providers has increased from 2000 to 2006, both within 7 days of discharge and within 30 days.
- PCPs play a smaller, but consistent role in delivering follow-up care.

Research has shown that outpatient care after inpatient care for mental illness or substance abuse is effective in reducing readmission for the same diagnosis.[11]

This measure evaluates provision of outpatient follow-up care by specialty, primary care providers (PCP) and other (non-physician or unspecified providers) within 7 days of discharge and within 30 days of discharge from an inpatient mental health or substance abuse stay. Two HMOs have conducted performance improvement projects on mental health services since 2000.

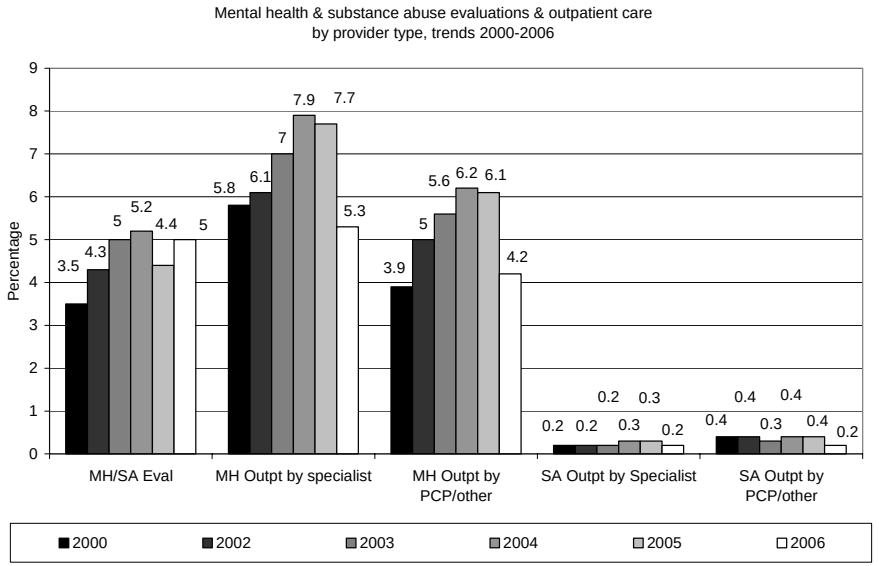
[11] *Evaluation and the Health Professions, Special Edition, State Medicaid Quality Programs*, "Outpatient Utilization Patterns and Quality Outcomes after First Acute Episode of Mental Health Hospitalization," Delmarva Foundation, December 2000.

Mental health / substance abuse-evaluations & outpatient care

Monitoring Measure

Data points—

- Access to mental health and substance abuse evaluations has increased from 3.5 percent in 2000 to 5 percent in 2006.
- Access to outpatient mental health care by both specialist and primary care providers increased in the period, but declined from 2005 to 2006.
- Access to outpatient substance abuse care from specialist and primary care providers remained about the same from 2000 to 2006.



Mental health and substance abuse (MH/SA) conditions can often be successfully treated on a day treatment or outpatient basis. Outpatient treatment is often preferred by enrollees over inpatient care. Thus, access to day and outpatient treatment services is both preferred by enrollees and useful to reduce the need for inpatient care.

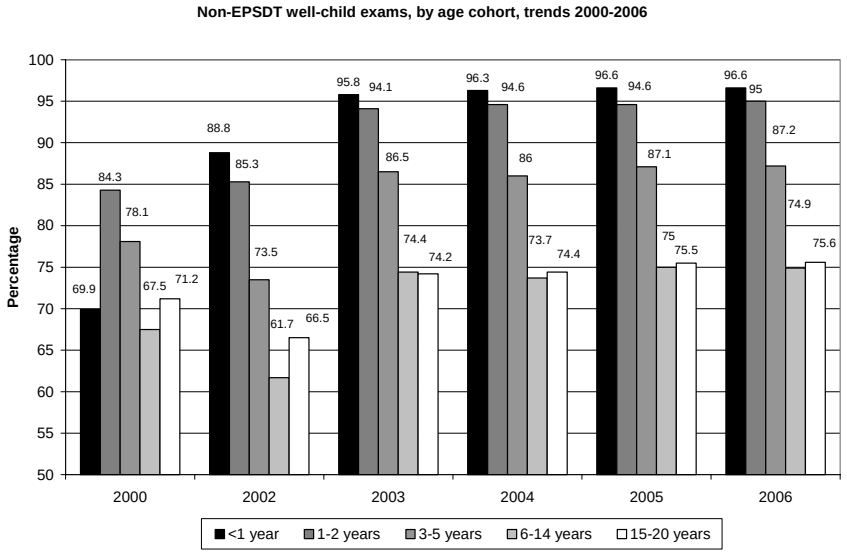
This measure tracks the provision of these services by provider type in order to gain insight into HMO network adequacy. Care by a specialist may be preferable or essential in some instances, however, primary care providers may also be able to provide services in many others.

Non-EPSDT well-child exams

Monitoring measure

Data points—

- The rate for children with at least one visit in the look-back period improved by 38.2 percent among children <1 year of age since 2000.
- The rate for children with at least one visit in the look-back period improved by 12.7 percent among children 1-2 year of age since 2000.
- Rates in all other age groups have also increased since 2000.



Non-EPSDT well-child visits are primary care visits that do not qualify as EPSDT visits (see page 16), but do result in delivery of preventive or other primary health services.

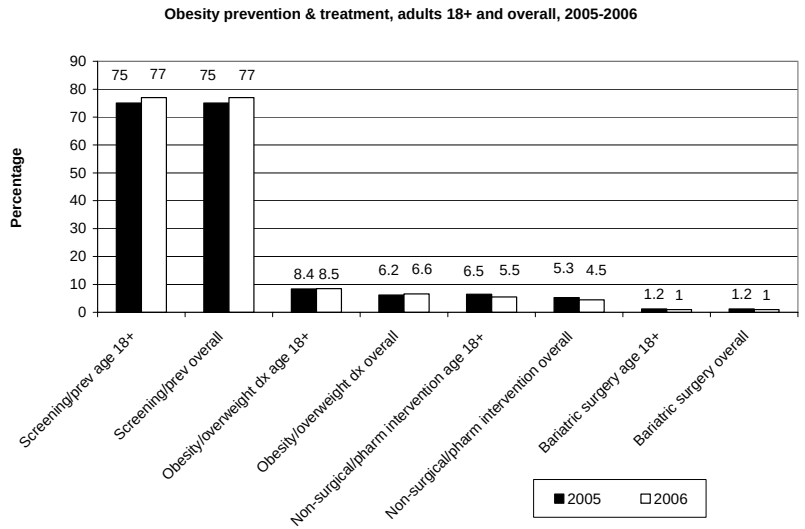
Research[12] has shown that states with the highest rates of provision of well-child visits had the lowest rates of preventable hospitalizations for those children. Conversely, states with the lowest rates of well-child care had the highest rates of preventable hospitalizations.

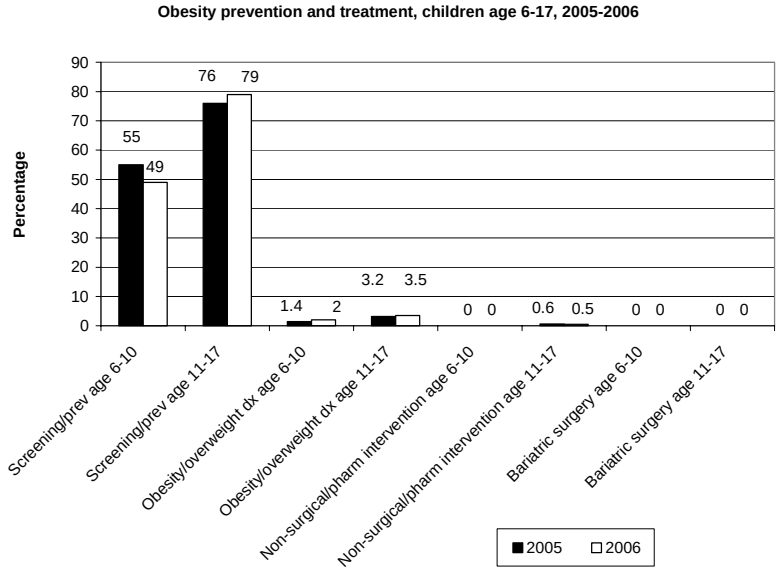
The authors of the study concluded that the "association between preventive care and a reduction in avoidable hospitalizations was robust and was consistent across the states and racial and ethnic groups."

[12] *Effectiveness of compliance with pediatric preventive care guidelines among Medicaid beneficiaries*. Hakim RB, Bye BV. July 2001. PEDIATRICS, Vol. 108, No.1:90-97.

Obesity prevention and treatment

Monitoring measure





Obesity is linked to increased risk for diabetes, hypertension, heart disease, disability and adverse outcomes of pregnancy, including prematurity and increased maternal and infant mortality.

This new monitoring measure is designed to address the need for comprehensive data to support more effective identification, prevention, and treatment of overweight and obesity among children and adults.

Three HMOs have conducted performance improvement projects on obesity-related topics since 2000.

New strategies are being developed to address obesity and overweight.

Data points—

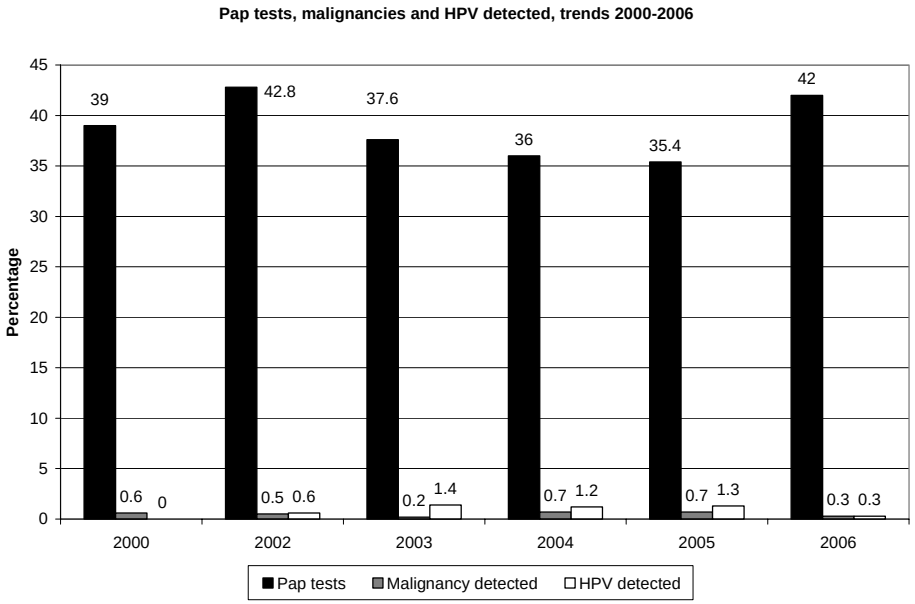
- The screening and preventive services rate for children and adults is fairly high.
- The period prevalence (cases detected by care encounters only in the look-back period, not overall) diagnosis rate for children is just over three percent and over eight percent among adults.
- Medications are used in about six percent of diagnosed cases among adults, less than one percent of diagnosed cases among children.
- Bariatric surgery to treat obesity is used in about one percent of diagnosed cases among adults, and has not been used in pediatric cases.

Pap tests-cervical cancer screening

Targeted Performance Improvement Measure

Data points—

- Provision of Pap tests has hovered around 40 percent since 2000.
- Malignancy detection rates have remained about the same-under one percent.
- HPV detection rate has remained about the same since 2002 at about one percent.



According to the Centers for Disease Control (CDC), cervical cancer remains a leading preventable cause of death among women. Women of child-bearing age make up a significant number of Medicaid/BadgerCare HMO enrollees. Consequently, providing early detection tests is an important service.

Early detection is relatively easy and is the key to a high probability of survival. The most common method for early detection is called the "Pap test." The Pap test is generally performed every three years, beginning when the woman becomes sexually active or by age 18 years. Thus, the Pap test is generally not required annually, and the measure is designed to take this into account.

According to the CDC, Human Papillomavirus (HPV) infection is a causal factor in more than 90 percent of cervical cancers. A new vaccine for HPV has been approved by the FDA and is likely to be an important tool in prevention of cervical cancer. This measure assesses the detection rates for malignancy and HPV infection.

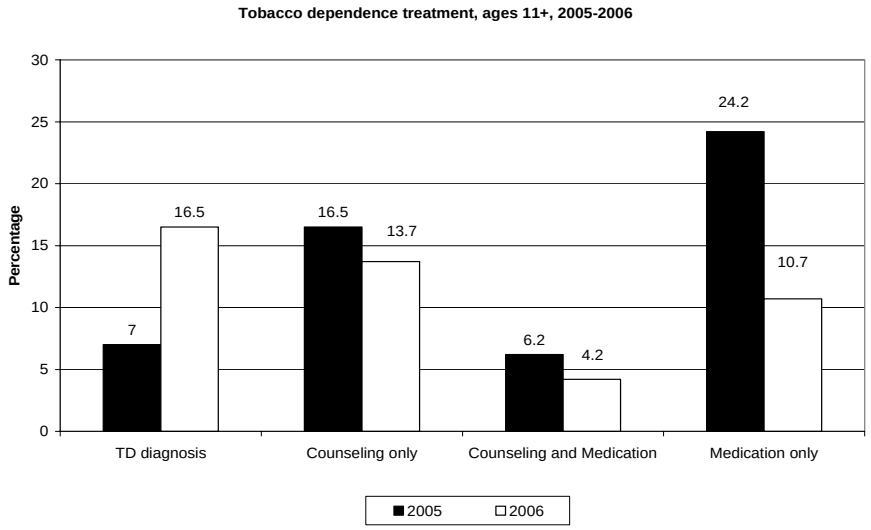
Three HMOs have conducted a performance improvement projects on increasing Pap test rates since 2000. In an effort to improve performance, the DHFS has moved the Pap test indicator from Monitoring Measure status to Targeted Performance Improvement Measure status and added it to the Goal-setting program.

Tobacco dependence treatment

Monitoring Measure

Data points—

- Period prevalence of the diagnosis of tobacco dependence doubled from 2005 to 2006. This is not overall prevalence—only prevalence of encounters in each year with the diagnosis.
- Use of counseling alone and counseling and prescription medication together declined slightly.
- Use of prescription medications alone declined by more than half.



According to the Agency for Healthcare Research & Quality (AHRQ), smoking:

- Results in Americans spending an estimated $50 billion annually on direct medical care for smoking-related illnesses. It is the nation's leading cause of preventable illness and death, killing more than 400,000 Americans a year as the result of smoking related diseases.
- Causes the loss of $47 billion in lost wages and productivity annually.

This measure assesses the period prevalence of the diagnosis of tobacco dependence, use of professional counseling with and without prescription medications and prescription medications alone in treatment. Evidence[13] suggests that professional counseling and medication used in combination are the most effective treatment modality.

A pay-for-performance incentive applies to tobacco dependence treatment. Four HMOs have conducted performance improvement projects on tobacco cessation. A collaborative effort between the University of Wisconsin Center for Tobacco Research & Intervention, the Division of Public Health and the Division of Health Care Financing is underway on tobacco cessation. Tobacco use status data is gathered on the New Enrollee Health Needs Assessment (NEHNA) survey.

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[13] U.S. Department of Health and Human Services, Public Health Service (PHS) 2000 *Clinical Practice Guideline: Treating Tobacco Use and Dependence.*